Chapter One

Nursing Facility Requirements and Services

Introduction

This chapter provides information for nursing facilities participating in North Carolina Medicaid.

In This Chapter

This chapter contains:

Provisions, Standards, and Requirements

Overview

All nursing facilities participating in Medicaid except intermediate care facilities for the mentally retarded (ICF/MRs) must provide the nursing facility level of care. The nursing facility level of care is assigned based on the needs of the recipient. A single facility may have a "distinct part" that participates in the Medicaid program as a nursing facility (NF), and another "distinct part" that participates in Medicare as a skilled nursing facility (SNF).

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Provisions, Standards, and Requirements, continued

Standards of Participation

A nursing facility **must** participate in Medicare to be enrolled as a Medicaid provider.

A nursing facility receiving Medicaid funding must be licensed by the North Carolina Division of Facility Services (DFS) as a nursing facility or by the state agency charged with licensure if the facility is located outside North Carolina borders.

Nursing facilities receiving Medicaid funding must comply with state and federal rules and regulations (see 42 CFR 483 – Requirements for States and Long Term Care Facilities).

Refer to the Basic Medicaid Billing Guide on DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm for additional information.

Provision of Services

A Medicaid certified nursing facility must provide or arrange for the provision of nursing and related services, and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. These services must be provided in accordance with the comprehensive assessment and plan of care. Pharmacy, dental, dietary, and related social services, as well as an ongoing program of activities must be available and must meet professional standards of quality.

Licensed nursing services must be provided 24 hours a day. For eight consecutive hours, seven days a week, the services of a registered professional nurse must be used.

Nurse aide training and competency evaluations are required for nurse aides employed in long-term care. DFS administers this program.

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Provisions, Standards, and Requirements, continued

Nursing Facility Requirements

In addition to the requirements listed below, criteria for the nursing facility level of care are covered in Chapter Four, Level of Care.

A nursing facility must meet the following requirements:

1. Have in effect a written transfer agreement with one or more participating hospitals providing for the transfer of residents between the hospital and the facility and the interchange of medical and other information;
2. Have policies (developed with the advice and periodic review of a professional group, including one or more physicians and one or more registered nurses) to govern the skilled nursing care and related medical or other services it provides;
3. Have a physician, registered nurse, or medical staff person responsible for the execution of such policies;
4. To be placed and to remain at the nursing facility level of care, every recipient must be certified and periodically recertified by a physician in accordance with federal and state requirements;
5. Each resident must be under the care and supervision of a physician;
6. Provide or arrange for the provision of physician services 24 hours per day in case of emergency;
7. Provide 24-hour licensed nursing care, with a minimum of eight hours of registered nurse coverage daily;
8. Maintain medical records on all residents (nurses' notes, physicians' notes, etc.);
9. Provide appropriate methods and procedures for dispensing and administering drugs and biologicals;
10. Be licensed in accordance with federal and state requirements by the DFS to provide medical, nursing, and rehabilitative services.
11. Must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. The assessment instrument that must be used is the Minimum Data Set (MDS). The MDS must be conducted per federal requirements in 42 CFR 483.20 – Resident assessment.
12. Nursing facilities participating in the Medicaid Case Mix Reimbursement System are required to participate in the MDS Validation Program.

Availability

Medicaid applicants/recipients who meet financial and level of care criteria are eligible for Medicaid nursing facility services.

Copayment

Medicaid recipients who are residents of a nursing facility are exempt from a copayment for the facility and are also exempt from copayment for any services rendered by practitioners at the facility or at another location.

Covered Services

Services and Items Covered In the Nursing facility Per Diem

While not all inclusive, the following items are covered in the per diem for each facility:

1. Room and board – this includes therapeutic diets with feeding assistance as needed. Nursing services are included in the room charge.
2. Therapeutic leave – Medicaid recipients are allowed sixty (60) days per calendar year. Prior approval must be obtained for more than 15 consecutive days. (Refer to page 1-8 for additional information on therapeutic leave.)
3. Nonprescription drugs, biologicals, vaccines, antigens, and toxins.
4. Rehabilitative Services – the nursing facility must provide or arrange for, under written agreement, specialized rehabilitative services upon the written order of the attending physician. If a facility does not offer rehabilitative services directly, it may not admit or retain residents in need of such care, unless it can arrange for qualified outside resources under which it assumes professional responsibility. Rehabilitative services include physical therapy, speech pathology, and occupational therapy.
5. Diagnostic Services – the nursing facility must provide or provide access to prompt laboratory, radiology, and other required diagnostic services. A facility with its own laboratory or radiology department must meet the applicable conditions of participation for hospitals. A facility not providing such services must make outside arrangements for these services. Services must be provided only by orders of the attending physician. The nursing facility must arrange for transportation to and from the source of service.
6. Social Services – the nursing facility must provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident.
7. Activity Services – the nursing facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.
8. Supplies, Appliances, and Equipment – must be furnished by the nursing facility to inpatients for their care, treatment, and use in the facility.
9. Routine Services–the following items and services, in addition to room, dietary, medical, and psychiatric services are always considered routine in nursing facilities:
   - all general nursing services
   - items furnished on a routine basis to all residents (e.g., patient gowns, water pitchers, basins, bedpans)
   - items stocked in gross supply and distributed or used individually in small quantities (e.g., alcohol, applicators, cotton balls, adhesive bandages, dressings and skin care items, antacids, aspirin, and other nonprescription drugs ordinarily kept on hand, suppositories, and tongue depressors). (Refer to Attachment A for a detailed list.)
   - items used by individual residents but are reusable and expected to be available (e.g., ice bags, bedrails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable medical equipment)
   - special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet (these supplements have been classified by the FDA as a food not a drug)
10. Ancillary services covered in the per diem include the following:
    - physical, speech, occupational, or other therapy
    - intravenous fluids or solutions
    - appropriate medically necessary supplies
11. Transportation to and from other participating Medicaid providers is covered in the per diem.

Non-covered Services and Restrictions

Services and Items Not Covered In Nursing Facility Per Diem

The following is a list of some noncovered services. This list is not all-inclusive. For information contact Medicaid's fiscal agent.

1. Telephone, television, newspapers, magazines
2. Guest tray
3. Morgue boxes, shrouds or burial wrappings
4. Private duty nurses and sitters
5. Tobacco products
6. Personal clothing
7. Medical photography
8. Bed-hold days

Pharmacy

Drugs

Over-the-counter (OTC) drugs are covered in the per diem and must not be billed to the resident.

There is no pharmacy copayment for nursing facility residents.

Refer to Clinical Coverage Policy #9, Outpatient Pharmacy Services, on DMA's website for additional information on outpatient pharmacy services.

Residents' Rights

Introduction

Provisions in OBRA '87 emphasized the importance of resident rights. Nursing facilities in North Carolina are subject to annual reviews by DFS to evaluate compliance with these and other Medicaid requirements. Residents' rights apply to all residents of a nursing facility that accepts Medicaid recipients regardless of the individual's payment source (e.g., private pay, Medicare).

Continued on next page

Residents' Rights, continued

Admission

The nursing facility must not require residents or potential residents to waive their rights to Medicare or Medicaid, nor require written or oral assurance that they are not eligible for, or will not apply for Medicare or Medicaid benefits.

The nursing facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission or continued stay in the facility. However, the nursing facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract without incurring financial liability to provide facility payment from the resident's income or resources.

In the case of a Medicaid recipient, the nursing facility must not charge, solicit, accept, or receive in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission, or continued stay in the facility. The provider may not charge a Medicaid recipient for failure to remain an inpatient for any agreed upon length of time or for failure to give advance notice of departure from the provider's facilities.

The nursing facility must inform each resident who is entitled to Medicaid benefits, **in writing**, at the time of admission to the nursing facility, when the resident becomes eligible for Medicaid, and periodically throughout the stay, of the following:

1. the items and services that are included in the nursing facility services under the State plan and for which the resident may not be charged
2. those items and services that the nursing facility offers and for which the resident may be charged and the amount of the charges for those services
3. changes that are made to items or services listed in 1. or 2. above

Married Residents

Each nursing facility resident has the right to share a room with his or her spouse when both married residents require nursing facility care and both spouses consent to the arrangement.

Continued on next page

Residents' Rights, continued

Transfer and Discharge

Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

A nursing facility must permit each resident to remain in the nursing facility and must not transfer or discharge a resident from the facility unless:

1. the resident's welfare and the resident's needs cannot be met in the facility (requires documentation in the clinical record by the resident's physician)
2. the resident's health has improved sufficiently so that the facility services are no longer needed (requires documentation in the clinical record by the resident's physician)
3. the health of individuals in the facility would otherwise be endangered (requires physician documentation in the resident's clinical record)
4. the safety of individuals in the facility is endangered
5. the resident has failed to pay for a stay at the facility
6. the facility ceases to operate

When a facility transfers or discharges a resident for any of the above reasons, those reasons must be documented in the resident's clinical record.

Before a nursing facility transfers or discharges a resident, a state-approved notice of transfer or discharge (see form DMA-9050, Attachment B) including appeal rights (see DMA-9051, Attachment C) must be issued to the resident and if known, a family member or legal representative, 30 days prior to discharge. This applies to **every** individual in a certified bed, regardless of pay source, and to all instances in which the resident is moved from the facility, including a transfer to a hospital. This does not, however, apply to situations in which a resident or the responsible party chooses to move to other placement.

A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

Bed-Hold

When a resident must be hospitalized, the resident or responsible party may arrange to reserve the resident's bed in the nursing facility (bed-hold). North Carolina Medicaid has no provision for bed-hold; it is a private agreement between the resident/responsible party and the nursing facility. The admission contract must state the charge for bed-hold and the resident must be notified of any changes that are made.

Continued on next page

Residents' Rights, continued

Readmission

A nursing facility resident who has been hospitalized and is ready for readmission to the nursing facility must be readmitted immediately to the first available bed in a semi-private room if the resident requires the services provided by the facility and is eligible for Medicaid nursing facility services.

Each nursing facility must have a written policy for readmission. If a recipient cannot be readmitted, the facility must notify the recipient, and, if known, the recipient's family or legal guardian. A notification must be provided as early as practical.

Therapeutic Leave

Each Medicaid eligible recipient occupying a nursing facility bed is entitled to take therapeutic leave in accordance with G.S. 108A-62.

Therapeutic leave must be a part of the resident's plan of care, ordered by his/her attending physician, with necessity for such leave documented in the resident's plan of care and therapeutic justification for each instance of such leave entered into the resident's medical record.

Medicaid places a limitation of 60 days for therapeutic leave per calendar year. A resident's 12-month entitlement period begins on January 1 and continues through December 31 of a calendar year. Prior approval is required when therapeutic leave exceeds 15 consecutive days.

Entitlement to therapeutic leave is not applicable in cases in which the leave is for the purpose of receiving either inpatient or nursing services provided elsewhere or at a different level of care in the facility of current residence when such services are billable to Medicaid.

The therapeutic justification for therapeutic leave is subject to review by the State or its agent during scheduled on-site medical reviews.

Facilities must reserve a resident's bed in the case of therapeutic leave and may not derive any Medicaid revenue other than the reimbursement for that bed during the period of absence.

Residents on therapeutic leave must be indicated as such on the facility's midnight census.

Nursing facilities must bill Medicaid for approved therapeutic leave days as regular residence days.

Nursing facilities must keep a cumulative record of therapeutic leave days taken by each resident for reference and audit purposes.

The official record of therapeutic leave days taken for each resident is maintained by the State or its agent.

Residents' Funds and Property

Personal Needs Allowance

A protected personal needs allowance fund is established for each resident for clothing and personal needs while residing in the nursing facility. This allowance is $30.00 per month for an aged, blind, or disabled individual.

Personal Funds

The nursing facility must establish a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the nursing facility on the resident's behalf. The system must preclude any comingling of resident funds with nursing facility funds or with the funds of any person other than the resident. The individual financial record must be available upon request to the resident or his/her legal guardian.

The facility must deposit any resident's personal funds in excess of $50.00 in an interest bearing account(s) that is separate from any of the facility's operating accounts and credit all interest earned on the resident's funds to his or her account. In pooled accounts, there must be a separate accounting for each resident's share. The facility must maintain a resident's personal funds not exceeding $50.00 in a non-interest bearing account, an interest bearing account, or petty cash fund. It is acceptable to charge the bank service fee on the interest bearing account against the interest earned and apply the net amount to each resident's account. Facilities are required to keep sufficient cash on hand to furnish residents with convenient access to cash when needed.

Surety Bond

A surety bond must be purchased to assure the security of all personal funds of residents deposited with the facility.

Request For Items And Services

The facility must not charge a resident or the resident's representative for any item or service not requested by the resident, nor require a resident or the resident's representative to request any item or service as a condition of admission or continued stay. The resident or the resident's representative requesting an item or service for which a charge will be made must be informed what the charge will be, prior to the resident receiving the item or service.

Restrictions on Use of Resident Funds

A resident's personal funds **must not** be used for:

1. items and services that are furnished as part of Medicaid-covered nursing facility care
2. services covered by Medicaid and furnished by other participating Medicaid providers
3. transportation to and from other participating Medicaid providers
4. commingling with facility funds

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Residents' Funds and Property, continued

Restrictions on Use of Resident Funds (continued)

5. operating costs to the facility
6. collateral for a loan for facility operating expenses
7. any of the following items: (non-inclusive listing)
    - haircuts and shampooing
    - bath soap
    - brush and comb
    - cotton balls; cotton swabs
    - dental floss, denture adhesive, cleaner, nonprescription mouth rinses
    - toothbrush, toothpaste
    - disinfecting soaps
    - shampoo and hair conditioner
    - hospital gowns
    - moisturizing lotion
    - nail care
    - personal laundry
    - razors, shaving cream
    - sanitary napkins and related supplies
    - specialized cleansing agents (skin or to fight infection)
    - tissues
    - towels, washcloths
    - deodorant
    - incontinence care and supplies
    - over the counter drugs
    - bathing

Refer to Attachment A for additional information.

Use of Resident Personal Funds

A resident's personal funds **may** be used for the following items and services if requested by the resident and the resident or the resident's representative is informed of the charge:

1. authorized cost-sharing in Medicaid-covered services, including patient liability to hospitals and nursing facilities
2. medical and health care not covered by Medicaid
3. personal needs including, but not limited to:
    - beauty shop and barber shop services
      Note: The nursing facility must provide or arrange for (with no charge to resident) shampooing, conditioning, and routine hair trimming as part of basic hygiene service rendered to residents. The resident, family member or representative must be informed upon admission and periodically thereafter of the method and schedule by which these services are provided. **If the resident elects** to use the service of a barber or beautician, and such services are outside the facility's method or schedule, then the services may be charged to the resident's funds
    - cigarettes, cigars, pipes, and tobacco
    - clothing
    - cosmetics; grooming items and services in excess of those covered by Medicaid or Medicare

Continued on next page

Residents' Funds and Property, continued

Use of Resident Personal Funds (continued)

- telephone
- television/radio
- personal comfort items such as notions, novelties, confections
- reading matter, flowers, plants, gifts to the resident
- social events and entertainment offered outside the scope of the activities program
- non-covered special care services such as privately hired nurses and/or aides
- specially prepared or alternative food requested instead of the food generally prepared by the facility
- private room, except when therapeutically required (e.g. isolation for infection control)

Refer to Private Room on page 1-12 for additional information.

Notice of Certain Balances

The facility must notify each resident who receives Medicaid benefits:

- when the amount in the resident's account reaches $200 less than the supplemental security income (SSI) resource limit for one person
- that the resident may lose eligibility for Medicaid or SSI if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person (42CFR Part 483.10).

Disposition of Funds Upon Discharge or Death

Upon the resident's discharge or transfer to another facility, an accounting of the resident's funds and property must be completed, paid, and delivered within thirty (30) days. Upon the death of a Medicaid resident, his or her balance in the personal needs fund must be accounted for and turned over to the administrator of the estate within thirty (30) days after death. If an administrator has not been appointed, the balance should be paid to the Clerk of the Superior Court within thirty (30) days after death. The funds and personal property will be disbursed by the Clerk of the Superior Court under provisions of North Carolina Statute §28A-25-6. Funds should be sent to the Clerk of the Superior Court of the county providing the Medicaid assistance. The letter remitting the funds should have the resident's full name, date of death, Medicaid identification (MID) number, and should identify the name of the county department of social services (DSS) that provided medical assistance.

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Residents' Funds and Property, continued

Private Rooms

A resident or his/her family may pay for a private room, provided the resident's physician has not ordered private accommodations, and such arrangements are not a condition of admission or continued stay in the facility.

The Medicaid per diem rate is for semiprivate rooms unless the recipient's attending physician orders a private room or if the only room available is private. The Medicaid payment plus any third party insurance payment and patient liability is payment in full under these circumstances.

When private accommodations are requested for the convenience and comfort of the resident and his or her family, the facility may charge the difference between the facility's private patient rates for semiprivate and private rooms, because Medicaid is paying for semiprivate accommodations. For example, if the Medicaid per diem for the resident's level of care is $75.00 and the facility's private rates for semiprivate and private rooms are $82.00 and $94.00 respectively, the charge for the private room can be no more than $12.00 per day.

Medicaid must get credit for all third party insurance payments up to the amount of the Medicaid payment. Third party payments cannot be used to pay the difference between the semiprivate and private rates until after Medicaid has been reimbursed in full.

Residents may use their own assets (not income) to pay the private room charge; however, the resident should be informed of the limited number of days those assets will cover. The value of assets that the resident may hold in reserve is only $2000.00.

Bed-Hold

When a resident must be hospitalized, the resident or responsible party who wishes to may arrange to reserve the resident's bed in the nursing facility (bed-hold). North Carolina Medicaid has no provision for bed-hold; it is a private agreement between the resident/responsible party and the nursing facility. The admission contract must state the charge for bed-hold and the resident must be notified of any changes as they are made.

Advance Directives

Background

Section 4751 of the Omnibus Reconciliation Act (OBRA) 1990, otherwise known as the Patient Self-Determination Act, requires certain Medicaid providers, including nursing facilities, to provide written information to all recipients 18 years and older about their rights under state law to make decisions concerning their medical care, to accept or refuse medical or surgical treatment, and to execute an advance directive (e.g., living will or health care power of attorney).

Effective January 1, 1998, a new law entitled "An Act to Establish Advance Instruction for Mental Health Treatment" (NCGS §122C-71–§122C-77) became effective. The law provides a method for an individual to exercise the right to consent to or refuse mental health treatment if the individual later becomes "incapable" (i.e., lacks the capacity or ability to make and communicate mental health treatment decisions). The advance instruction becomes effective when delivered to the individual's physician or mental health treatment provider, who then makes it part of the individual medical record.

Advance Directives Brochure

The Division of Medical Assistance, in conjunction with an advisory panel, has developed the required summary of state law concerning residents' rights that must be distributed by providers. This brochure is entitled "Medical Care Decisions and Advance Directives: What You Should Know." Refer to Attachment D for a print ready copy of the brochure.

The brochure is two pages, should be photocopied on the front and back of one sheet of paper and folded in half to form a four-page brochure. Indicate in the box on the last page a contact for the resident to obtain more information. The brochure should be copied as is. If providers choose to alter the document graphically, they may not change or delete text, or the order of paragraphs. A provider-published brochure must include the NC DHHS logo and production statement on page four of the folded brochure.

Ambulance and Non-Ambulance Transportation

Non-ambulance Transportation

Medicaid reimburses nursing facilities for non-ambulance transportation of Medicaid-eligible residents to receive medical care that cannot be provided in the facility.

Family members are encouraged to provide transportation as a means to provide important family and social support to the resident.

The facility cannot charge (or assess) the family or the resident's funds for the cost of this routine transportation. The facility is responsible for arranging or providing non-ambulance transportation for all Medicaid recipients. The facility may contract with providers (including county-coordinated transportation systems) to provide transportation. The facility may provide transportation services using its own vehicles, if this is more cost-effective.

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Ambulance and Non-Ambulance Transportation, continued

Non-emergency Ambulance Transportation

Non-emergency ambulance transportation is covered for nursing facility residents when any other means of transportation would endanger the resident's health **and** it is medically necessary that the resident be transported via stretcher due to a medical/physical condition.

Medical Necessity

Medical necessity is when the resident's condition requires ambulance transportation and any other means of transportation would endanger the resident's health or life. Medicaid covers ambulance services only if they are furnished to a resident whose medical condition is such that other means of transportation would be contraindicated.

Non-covered Transportation Services

The following transportation services are considered as non-covered for nursing facility residents:

- routine transportation
- transportation from the nursing facility to the emergency room for medical services that could be rendered at the nursing facility
- transportation of a deceased resident if pronounced dead prior to the call for pick-up
- transportation from a nursing facility to the outpatient department of a hospital for medical services that could be rendered at the nursing facility

Hospice Care for Nursing Facility Residents

Hospice Care

Refer to the Hospice Services policy on DMA's website at http://www.dhhs.state.nc.us/dma/mp.mpindex.htm for information on hospice services.

Program Integrity Reviews

Program Integrity Reviews

Refer to the Basic Medicaid Billing Guide on DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm for information on Program Integrity reviews.

Attachments

Attachment A: Items Included in Per Diem
Attachment B: Notice of Transfer/Discharge (DMA-9050) and Instructions
Attachment C: Hearing Request Form (DMA-9051)
Attachment D: Advanced Directives Brochure

ITEMS INCLUDED IN THE PER DIEM FOR NURSING FACILITIES

DRESSING AND SKIN CARE ITEMS (Not all inclusive)

ABD Pads
Applicators, Cotton-tipped
Arm Slings
Bandages, elastic or cohesive
Band-Aids
Bath Soap
Body Oil
Composite Pads
Corn Starch
Cotton Balls
Decubitus Ulcer Pads
Deodorant
Disposable Ulcer Pads
Disposable Underpads
Shampoo
Eye Pads
Finger Cots
Gauze
Lotions
Nonprescription Creams
Nonprescription Medicated Powder
Ointments
Petroleum Jelly
Powder
Sponges
Sterile Pads
Surgical Dressing
Surgical Pads
Underpads
Disposable Diapers

PERSONAL HYGIENE AND LAUNDRY (Not all inclusive)

Shampoo
Brush
Comb
Specialized Cleansing Agents (skin)
Razors
Toothpaste
Denture cleaner
Moisturizing lotion
Cotton balls
Deodorant
Towels
Patient gowns
Personal laundry (no dry cleaning)
Hair Conditioner
Bath Soap
Disinfecting soaps
Shaving cream
Toothbrush
Denture adhesive
Dental floss
Tissues
Cotton swabs
Washcloths
Sanitary napkins and related supplies
Hair cuts
Nail care

MEDICAL SUPPLIES AND EQUIPMENT (Not all inclusive)

Ace Bandages
Adhesive and Adhesive Removal
Adhesive Tape
Airway, disposable
Airway (Oral, reusable)
Anti-embolic hose
Air mattress, disposable
Asepto-Syringes
Aspirating catheters
Basins
Bed frame equipment–turning frames, bedrails, trapeze bars, foot cradles
Bed pans, fracture and regular
Bedside utensils
Bibs
Bottles, specimen
Brown paper bags (isolation only)
Buck Extension
Canes, regular and customized
Cannula
Catheter, aspirating
Catheters, disposable
Catheter, 3-way
Clysis set
Colostomy bags, belt, gasket, irrigation syringe
Crutches, regular and customized
Douche bags
Drainable stoma bags
Drainage bags
Enema cans and supplies
Finger splints
Flex trach tube
Furacin gauze
Gloves, sterile and unsterile
Gowns (isolation only)
Gowns, patient
Heat cradle
Heating pads
Heel protectors
Ice Bags
Incontinency pads and pants, disposable or resuable
Infusion arm boards
Inhalation therapy supplies (aerosol inhalators, nebulizer and replacement kits, steam vaporizers, IPPB-intermittent positive pressures breathing machine, oxygen tents and masks)
Invalid rings, all sizes
IPPB
Irrigation syringes or bulbs
I.V. solutions
K Pads, water-heated
Lemon-glycerine swabs
Levine Tubes
Linens
Mattresses (air, air P.R., alternative pressure, flotation water)
Medicine dropper
nasal catheter
needles, all types and sizes
Nebulizer for moist nebulization
Oxygen
Oxygen mask
Oxygen nebulizer and regulator
Pads, eye
Pad, foam
Pad, foam, self-adhering
Pads, flotation
Pads, non-stick
Paper mask (isolation only)
Paper tape
Patient lift
Pharmadine
Pillowcase (disposable, isolation only)
Pilo Pump
Pitchers
Pressure pads, donut
Pumps, aspiration and suction
Restraints
Roller gauze
Saline, sterile (30 cc)
Sandbags
Scales suitable for NF purposes
Scalp vein set
Scalpels, blades, disposable scalpels
Sheepskin
Sheets, disposable (isolation only)
Sheets, Half, disposable (isolation only)

MEDICAL SUPPLIES AND EQUIPMENT, Continued
(Not all inclusive)

Sitz bath, disposable
Skin Gel
Solutions, sterile, irrigating
Specimen cups
Speculum, vaginal, disposable
Splint, finger or wrist
Suture and needle, sterile
Skin Closures
Suction equipment
Syringes, all types and sizes, disposable and reusable
Tape–butterfly; for lab tests; non-allergenic, surgical and adhesive
Tissue, bedside
Tissue wipes
Tongue depressors
Trach soap
Tracheostomy tubes
Tracheostomy brush
Tracheostomy mask
Tray, catheter (disposable)
Tray, irrigation (disposable)
Tray, I.V. set
Tray, suture
Tray, suture removal
Tray, tracheostomy
Tray, urethral catheter
Tray, service
Tube, stomach
Tube, urinary drainage
Tubing, cannula, nasal
Tubing, catheter, all types, including plugs, clamps and drainage bags
Tubing, drainage, all types
Tubes, nasogastric, NG feeding and stomach
Tubing, I.V.
Tubing, oxygen
Tubing, suction (large bubble)
Urinals, male and female
Urine, leg bath (disposable)
Uro shealth catheter
Urostomy Bags
Vaseline gauze
Walkcane
Walkers
Water, sterile (quart, gallon, etc.)
Wheelchairs

NURSING HOME
NOTICE OF TRANSFER/DISCHARGE

1) DATE OF NOTICE: _____

2) RESIDENT: _____
FACILITY: _____
ADDRESS: _____
ADMINISTRATOR: _____ PHONE: _____

3) **DATE OF TRANSFER/DISCHARGE:** _____

Under federal law (42 U.S.C 1396r(c)(2)(A); 42 CFR 483.12), you may only be transferred or discharged from this nursing facility for one of the following reasons:

- It is necessary for your welfare and your needs cannot be met in this facility;
- Your health has improved sufficiently so that you no longer need the services provided by this facility;
- The safety of individuals in this facility is endangered;
- The health of individuals in this facility would otherwise be endangered;
- You have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at this facility; or
- The facility ceases to operate.

4) **THE REASON FOR THIS NOTICE OF YOUR TRANSFER/DISCHARGE IS:** _____
_____

5) In addition to notifying you (i.e. the resident) of this transfer/discharge, _____ has also been notified.
(family member/legal representative)

6) Check **ONE** and **INDICATE LOCATION** below:

{ } THIS FACILITY PLANS TO **TRANSFER** YOU TO:
{ } THIS FACILITY PLANS TO **DISCHARGE** YOU TO:

NAME OF FACILITY/LOCATION: _____
ADDRESS: _____ PHONE: _____

You have the **RIGHT TO APPEAL** this transfer/discharge to the N.C. Division of Medical Assistance **WITHIN 11 DAYS** of the date of this notice if you want to continue to stay at this facility. The appeal will be at no cost to you or your representative. The request for an appeal (see attached form) must be received by the hearing officer no later than the 11th day or your right to appeal is waived. If you wish to review your medical record, we must allow you to see it no later than five working days prior to the hearing.

You may wish to contact your regional **LONG TERM CARE OMBUDSMAN** for help in mediation with the facility or for assistance in obtaining free legal services, if qualified. The ombudsman's name, address and phone number is:

7) NAME: _____

ADDRESS: _____ PHONE: _____

If mentally ill or developmentally disabled, you or your family member or legal representative may wish to contact: GOVERNOR'S ADVOCACY COUNCIL FOR PERSONS WITH DISABILITIES, 2113 Cameron Street, Suite 218, Raleigh, N.C. 27605. Telephone number (919) 733-9250 or 1-877-235-4210.

8) _____ _____
Signature of Administrator Date

DMA-9050 (8/04)

INSTRUCTIONS FOR COMPLETING THE TRANSFER/DISCHARGE NOTICE

1) Enter the date the notice is served upon the resident and representative.

2)
Resident:	Enter the resident's complete name.
S.S. #:	Enter the resident's social security number.
Facility:	Enter the name of your facility.
Address:	Enter your facility's complete mailing address.
Administrator:	Enter the name of your facility's administrator.
Phone:	Enter your facility's area code and telephone number.

3) Enter the date on which you intend to transfer or discharge the resident.

4) Enter the reason your facility is transferring or discharging this resident. If necessary to provide a full explanation, additional information may be attached.

5) Enter the name of the family member or legal representative upon whom this notice has been served. If the facility has been made unable to ascertain the name of a family member or legal representative, indicate "unknown" in the space provided.

6) Enter a mark {X} in the appropriate space for either Transfer or Discharge, **AND** enter the name of the facility or other location to which the resident is being transferred or discharged. Enter the address and telephone number of the intended location.

7) Enter the name, address and telephone number of the appropriate Long Term Care Ombudsman for your region.

8) Administrator signs and dates the form as your facility's representative.

NURSING HOME
HEARING REQUEST FORM

TO BE COMPLETED BY NURSING FACILITY

Resident: _____

Facility: _____

Date of Transfer/Discharge Notice: _____

Date of Scheduled Transfer/Discharge: _____

Dear Hearing Officer:

I would like to request a hearing to appeal the above resident's notice of transfer/discharge. I would like for the hearing to be held (please check one):

[ ] By telephone

[ ] In person in Raleigh, NC

Name of Person Requesting Hearing: _____

Address: _____

_____

Telephone Number: _____ Date: _____

Signature: _____

(The signature of resident or family member or legal representative authorizes release of medical records)

If you have questions, you may contact the Division of Medical Assistance Hearing Office by calling (919) 647-8200 or by calling the CARELINE (Monday-Friday, 8:00 AM – 5:00 PM) at 1-800-662-7030 and asking for the Hearing Office.

PLEASE COMPLETE THE ABOVE INFORMATION AND **ATTACH A COPY OF THE NOTICE OF TRANSFER OR DISCHARGE THAT WAS ISSUED TO YOU BY THE NURSING FACILITY. YOUR REQUEST MUST BE RECEIVED NO LATER THAN ELEVEN DAYS FROM THE DATE OF THE NOTICE OF TRANSFER/DISCHARGE. YOUR REQUEST FORM MAY BE SUBMITTED BY MAIL OR FACSIMILE TO:**

DMA Hearing Unit
Division of Medical Assistance
2501 Mail Service Center
Raleigh NC 27699-2501

Fax (919) 715-6394

DMA-9051 (8/04)

Doctor and each health care agent you named of the change. You can cancel your advance instruction for mental health treatment while you are able to make and make known your decisions, by telling your doctor or other provider that you want to cancel it.

Whom should I talk to about an advance directive?

You should talk to those closest to you about an advance directive and your feelings about the health care you would like to receive. Your doctor or health care provider can answer medical questions. A lawyer can answer questions about the law. Some people also discuss the decision with clergy or other trusted advisors.

Where should I keep my advance directive?

Keep a copy in a safe place where your family members can get it. Give copies to your family, your doctor or other health/mental health care provider, your health care agent, and any close friends who might be asked about your care should you become unable to make decisions.

What if I have an advance directive from another state?

An advance directive from another state may not meet all of North Carolina's rules. To be sure about this, you may want to make an advance directive in North Carolina too. Or you could have your lawyer review the advance directive from the other state.

Where can I get more information?

Your health care provider can tell you how to get more information about advance directives by contacting:

This document has been developed by the North Carolina Division of Medical Assistance in cooperation with the Department of Human Resources Advisory Panel on Advance Directives 1991. Revised 1999.

Medical Care Decisions and Advance Directives
What You Should Know

What are My Rights?

Who decides about my medical care or treatment?

If you are 18 or older and have the capacity to make and communicate health care decisions, you have the right to make decisions about your medical/mental health treatment. You should talk to your doctor or other health care provider about any treatment or procedure so that you understand what will be done and why. You have the right to say yes or no to treatments recommended by your doctor or mental health provider. If you want to control decisions about your health/mental health care even if you become unable to make or to express them yourself, you will need an "advance directive."

What is an "advance directive"?

An advance directive is a set of directions you give about the health/mental health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. One way is called a "living will"; another is called a "health care power of attorney"; and another is called an "advance instruction for mental health treatment."

Do I have to have an advance directive and what happens if I don't?

Making a living will, a health care power of attorney or an advance instruction for mental health treatment is your choice. If you become unable to make your own decisions; and you have no living will, advance instruction for mental health treatment, or a person named to make medical/mental health decisions for you ("health care agent"), your doctor or health/mental health care provider will consult with someone close to you about your care.

Living Will

What is a living will?

In North Carolina, a living will is a document that tells others that you want to die a natural death if you are terminally and incurably sick or in a persistent vegetative state from which you will not recover. In a living will, you can direct your doctor not to use heroic treatments that would delay your dying, for example by using a breathing machine ("respirator" or "ventilator"), or to stop such treatments if they have been started. You can also direct your doctor not to begin or to stop giving you food and water through a tube ("artificial nutrition or hydration").

Health Care Power of Attorney

What is a health care power of attorney?

In North Carolina, you can name a person to make medical/mental health care decisions for you if you later become unable to decide yourself. This person is called your "health care agent." In the legal document you name who you want your agent to be. You can say what medical treatments/mental health treatments you would want and what you would not want. Your health care agent then knows what choices you would make.

How should I choose a health care agent?

You should choose an adult you trust and discuss your wishes with the person before you put them in writing.

Advance Instruction for Mental Health Treatment

What is an advance instruction for mental health treatment?

In North Carolina, an advance instruction for mental health treatment is a legal document that tells doctors and health care providers what mental health treatments you would want and what treatments you would not want, if you later become unable to decide yourself. The designation of a person to make your mental health care decisions, should you be unable to make them yourself, must be established as part of a valid Health Care Power of Attorney.

Other Questions

How do I make an advance directive?

You must follow several rules when you make a formal living will, health care power of attorney or an advance instruction for mental health treatment. These rules are to protect you and ensure that your wishes are clear to the doctor or other provider who may be asked to carry them out. A living will, a health care power of attorney and an advance instruction for mental health treatment must be written and signed by you while you are still able to understand your condition and treatment choices and to make those choices known. Two qualified people must witness all three types of advance directives. The living will and the health care power of attorney also must be notarized.

Are there forms I can use to make an advance directive?

Yes. There is a living will form, a health care power of attorney form and an advance instruction for mental health treatment form that you can use. These forms meet all of the rules for a formal advance directive. Using the special form is the best way to make sure that your wishes are carried out.

When does an advance directive go into effect?

A living will goes into effect when you are going to die soon and cannot be cured, or when you are in a persistent vegetative state. The powers granted by your health care power of attorney go into effect when your doctor states in writing that you are not able to make or to make known your health care choices. When you make a health care power of attorney, you can name the doctor or mental health provider you would want to make this decision. An advance instruction for mental health treatment goes into effect when it is given to your doctor or mental health provider. The doctor will follow the instructions you have put in the document, except in certain situations, after the doctor determines that you are not able to make and to make known your choices about mental health treatment. After a doctor determines this, your Health Care Power of Attorney may make treatment decisions for you. An advance instruction for mental health treatment expires after two years.

What happens if I change my mind?

You can cancel your living will anytime by informing your doctor that you want to cancel it and destroying all the copies of it. You can change your health care power of attorney while you are able to make and make known your decisions, by signing another one and telling your